TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Eradio Arredondo, M.D.

Respondent Name
Federated Service Insurance Company

MFDR Tracking Number
M4-16-3285-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
June 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
Shoulder IR w/ ROM = $300.00
Rib IR = $150.00
Concussion IR = $150.00
Leg IR = $150.00
total Paid = $950.00
Balance Due = $150.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per rule 134.204 Subsection (J) Subsection (4) Subparagraph (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. $950.00 was allowed for the three body areas."

Response Submitted by: Federated

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2016	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Notes: "There will be no additional allowance for these charges. Per the Texas DWC rules, as supported in the documentation you submitted with this appeal, the provider may bill for a MAXIMUM of 3 BODY AREAS: The spine & pelvis, upper extremities and hands, and lower extremities (including feet). The concussion would fall under non musculoskeletal body areas and would be reimbursed on line 2-$50.00 for a special areas. The provider may take this matter to medical dispute resolution for further disposition."

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   28 Texas Administrative Code §134.204(j)(4) states:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and,
   (III) lower extremities (including feet).
   (ii) The MAR for musculoskeletal body areas shall be as follows.
   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area; and
   (-b-) $150 for each additional musculoskeletal body area.
   (D) …
   (i) Non-musculoskeletal body areas are defined as follows:
   (I) body systems;
   (II) body structures (including skin); and,
   (III) mental and behavioral disorders.
   (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
   (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of right shoulder sprain, left leg contusion, rib fractures, concussion/PTSD. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the structures of the chest, including ribs, in the respiratory systems chapter. For this reason, it is considered a body system in the non-musculoskeletal category. Page 4 of the submitted medical documentation finds that the requestor based his impairment of the concussion/PTSD on the findings of a psychological evaluation. For this reason, it is considered in the medical and behavioral category. Therefore, the correct MAR for the impairment examination is $750.00.

   See the table below for a detailed analysis:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Right Shoulder (ROM)	Musculoskeletal	Upper Extremities	$300.00
IR: Left Leg		Lower Extremities	$150.00
IR: Rib Fractures	Respiratory System	Body Systems	$150.00
IR: Concussion/PTSD	Mental and Behavioral	Mental/Behavioral	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

2. The total MAR for the disputed services is $1100.00. The insurance carrier paid $950.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 16, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.